Special Olympics

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New □ or Update □

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS GEORGIA

Valid Application for Participation is mandatory for all training and competitions.

4000 Dekalb Technology Parkway • Building 400, Suite 400 • Atlanta, Georgia 30340 • 770-414-9390 • Fax: 770-216-8339

Athlete Nar	ne	_
Area	Agency	

SECTION A. ATHLETE HEALI	III INFORMATION (SHOULD DE SUDMITTED EVERT 3 TEARS)	
Social Security Number (Athlete) Required For Identification Only	Birthdate	MEDICAL CLEARANCE PLEASE CHECK MEDICAL INFORMATION Does the athlete have:
Athlete's Name (last name, space, first name)	M M D D Y Y Sex (M or F)	1. Heart Problems Yes □ No □
		2. Diabetes Yes □ No □ 3. Seizures/Epilepsy Yes □ No □
		4. Major Surgery/Serious Illness Yes □ No □
Agency Name	Is the athlete employed? ☐ Yes ☐ No	5. Parent/Sibling (under 40) died of heart disease Yes □ No □
		6. Down Syndrome Yes □ No □
	If so, where?	If athlete is Down Syndrome, have x-rays of the C1-C2 vertebrae been taken and examined?
Athlete's Mailing Address		Yes □ No □
	Background (optional):	Date of x-ray Does the athlete have Atlanto-axial
	☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American	Instability? Yes □ No □ 7. Vision Problems/Blind Yes □ No □
Athlete's City	Other	8. Hearing Loss/Deaf Yes □ No □
		9. Does athlete use wheelchair? Yes □ No □
	Email	Other
State Zip Code Parent's/Guardian's Daytime Telephone	_ Email	Current Medications Dosage
	Emergency Contact Phone ()	
	Required for emergency purposes	
HEALTH INSURANCE & EMERGENCY INFORMATION		
Medicaid Number Health Insurance Company	Policy Number	
Medicald Number Health insurance Company	roncy Number	Allergies (Medication, Food, Insect Bites):
PARENT OR GUARDIAN AUTHORIZATION AND MEDIA RELEASE		
On my own behalf or as the undersigned parent or legal guardian of the above named athlete, I he I represent and warrant to you that the athlete is physically and mentally able to participate in Spe		
I understand that if the athlete has Down Syndrome he/she cannot participate in sports or events v	Date of Last Tetanus Shot:	
upper spine unless a full radiological examination establishes the absence of Atlanto-axial Instabi		
equestrian sports, artistic gymnastics, diving, pentathlon, high jump, alpine skiing, soccer, butterfly stroke and diving starts in swimming. On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to		*A HEALTH SCREENING BY A
property of myself and the athlete. In permitting the athlete to participate, I am granting permissi	on to Special Olympics Georgia to use the name, likeness, voice and words of the athlete in	LICENSED EXAMINER IS REQUIRED EVERY 3 YEARS FOR ATHLETES
television, radio, films, newspapers, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purpose and activities of Special Olympics and in appealing for funds to support such activities.		WITH "YES" CHECKED ON 1-5*
If I am not personally present at Special Olympics activities in which the athlete is to compete, so as to be consulted in case of necessity, you are authorized on my behalf and at my account to take		SECTION B
such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete. By signing this form I authorize Special Olympics		MEDICAL CERTIFICATION
and/or its agents to make an independent investigation of my background, including those maintained by both public and private organizations and all public records. I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes program that provides individual screening assessments of health status and health care needs in the areas of:		I have examined the above named athlete and, in my
vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation to participate in the		opinion, there is no mental or physical reason why he or
Healthy Athletes Program.		she should not participate in Special Olympics sports training and competition program. Further information
I, THE UNDERSIGNED ADULT ATHLETE, have read and fully understand the	I, THE UNDERSIGNED PARENT OR GUARDIAN of the above specified athlete,	will be forwarded if required. Current medication, if any, is specified with dosage on this application.
provisions of the above release and/or have had them explained. I hereby agree that I will be bound thereby and shall defend Special Olympics Georgia and hold it harmless	have read and fully understand the provisions of the above release and have explained them to said athlete. I hereby, agree that I and said minor will be bound thereby, and I	
from disaffirmation thereof. I acknowledge and agree that the above information is	shall defend Special Olympics Georgia and hold it harmless from disaffirmation thereof	COMMENTS
accurate.	by said minor. I acknowledge and agree that the above information is accurate.	
		Examination Date
Athlete	Signature of Parent	Signature
	and/or Legal Guardian	Print Name
Witness	Print Name Date	Address
Witness Date	riiii naiiie Date	CityState Zip
A HEALTH SCREENING PERFORMED BY A LICENSED	EXAMINER IS REQUIRED FOR INITIAL PARTICIPATION	Phone
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INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION

SECTION A - ATHLETE HEALTH INFORMATION/PARENT GUARDIAN AUTHORIZATION AND

information, medications and allergies sections must be completed by a parent, guardian, or adult athlete. THE PERSON PROVIDING THE INFORMATION MUST SIGN AND DATE THE FORM IN THE SPACE PROVIDED. (IF SIGNED BY AN ATHLETE THERE MUST BE A WITNESS SIGNATURE). All athlete information, emergency information, health and accident insurance information, health

SECTION B - MEDICAL CERTIFICATION

The bottom section of the form labeled "Medical Certification" must be completed <u>SIGNED</u> and <u>DATED</u> LICENSED EXAMINER IS REQUIRED FOR INITIAL PARTICIPATION IN SPECIAL OLYMPICS. by a licensed Physician, Physician Assistant or Chiropractor. A HEALTH SCREENING BY

PROVIDED in order for the State office to accept and process the Application. The State office should get All signatures, dates, addresses, phone numbers, birth date, and health information MUST BE the ORIGINAL WHITE COPY and the Local Coordinator should keep the YELLOW COPY

A vs. AB APPLICATION FOR PARTICIPATION
The following guidelines will be used to determine "A" vs. "AB" applications:

- An Application will be considered an "A" Application if questions 1-5 of Section A are answered NO. When this application is up for renewal (every 3 years) only Section A - Athlete Health Information will need to be completed. No examiner's signature will be required under Section B - Medical Certification if application is completed before expiration date.
- An application will be considered an "AB" Application if any questions 1-5 of Section A are answered YES. An examiner's signature is required to have medical clearance of existing conditions. When this Application is up for renewal an examiner's signature is required.
- "AB" Application or vice versa. REMEMBER: If an application changes from A to AB or vice An athlete can have an "A" Application one time and the next time the Application could be an under Section B - Medical Certification.

A parent/guardian or an adult athlete must sign Section A of the Application for Participation. If Section A of the Application is signed by an adult athlete then a family member, friend or coach must also sign Section A of the Application.

fitness, each athlete's ability to train and compete in Special Olympics. SOGA offers six Healthy Athletes The mission of the Special Olympics Healthy Athletes Program is to improve, through better health and podiatry and physical therapy. The Healthy Athletes program is not mandatory; any athlete may elect not to go through the screening. Please call 770-414-9390 with questions about the program.